

Caseload Management Guidelines for Benefit Specialists

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Since Wisconsin's elder benefit specialists (EBS) and disability benefit specialists (DBS) follow a similar service model, they may be able to use similar strategies for caseload management. The following guidelines are designed to assist Aging and Disability Resource Centers (ADRCs) and other local agencies that employ benefit specialists in generating strategies to provide prompt service to customers while making the best use of limited staff and resources.

Benefit specialists, like all ADRC staff, are oftentimes challenged by the high demand for services, prompting managers to wonder whether it is appropriate to cut back on services, establish a wait list or implement other measures to control caseloads. The best approach to caseload management for benefit specialists begins with a careful assessment of the current caseload and incorporates a range of tactics—call triage, trained volunteers and staff coordination, public outreach and other time-saving techniques – to ensure that core program services are available at all times to community members who need them.

1. Assess Current Caseload

Any caseload management strategy requires an initial assessment and ongoing monitoring of the caseload. A benefit specialist's **caseload** is defined as the number of cases open at any given point in time.

For a benefit specialist, a "case" represents a single issue, or a set of closely inter-related issues, that the benefit specialist has agreed to assist the client in resolving. A benefit specialist opens a client case when assisting with a specific issue and closes the case when the issue is resolved. A benefit specialist may open more than one case for a client if the benefit specialist is assisting the same client with multiple distinct issues. The length of time that a case remains open varies considerably depending upon the nature of the client's issue. Some cases are closed in one or two days; others remain open for several weeks or months; and a few remain open for a year or more. Some open cases are relatively inactive while a client is awaiting a hearing date or a hearing decision.

The optimal caseload for a benefit specialist will vary based on the following factors:

- **Availability and Experience-Level** – The number of cases regarded as manageable depends on a benefit specialist's FTE status and his/her level of experience.
- **Type of Issues** – Cases can be categorized according to the issues involved. When an increase in cases is clearly related to a specific issue, the caseload management strategy should take this into account. For example, you might observe a high percentage of cases in January related to Medicare Part D enrollment errors; since Medicare Part D enrollment errors are generally seasonal and resolved in a matter of weeks, a short-term strategy may be implemented to handle the increase in demand.
- **Complexity of Issues** - Some cases involve complex issues that require extensive research or writing, while other cases are simple and straightforward. For example,

appeals and hearing requests are time-consuming, while a question about Medicare coverage of a nursing home stay may be relatively easy to resolve.

- **Status of Disability Determinations** – The majority of DBS cases involve disability determinations. During preparation for an initial application or an appeal, these cases are time-consuming. By contrast, when an application or appeal decision is pending, the case remains open but requires little action. When considering whether a DBS caseload is manageable, it is important to consider the proportion and status of open cases that involve disability determinations.
- **Information-Only Contacts** – In addition to open cases, a caseload management strategy should take into account the number and nature of brief information-only contacts a benefit specialist handles. In some agencies, information-only services represent a significant portion of the benefit specialist's workload. The number and nature of information-only contacts with a benefit specialist will vary depending upon the extent to which I & A Specialists are able to answer basic questions about public benefits and what is defined as an appropriate benefit specialist referral.
- **Level of Assistance Provided.** Benefit specialists may adjust their level of involvement in a case depending upon the client's ability to perform tasks independently and his/her system of supports (e.g., legal guardian, case manager, etc.). Some clients need only information and advice, others need help to fill out forms and gather documentation, and a few will require direct representation.

It is best to monitor and assess a benefit specialist's caseload on a routine basis in order to detect and respond to caseload management problems quickly. By monitoring the caseload, supervisors will be in a better position to respond when a benefit specialist is absent for an extended period of time or a benefit specialist position becomes vacant. Caseload assessment will be easier if the benefit specialist maintains current and complete client records in their program database. If data is kept current, the benefit specialist should be able to provide a report to his/her local supervisor about his/her caseload, including the number of open cases and the type of issues, on a quarterly basis or as often as needed.

Since attorneys are responsible for substantive oversight of benefit specialists' work, they are often the first to learn about caseload management problems. The assigned attorney should alert the local agency supervisor to any such problems. When a benefit specialist's caseload is too large, an agency must allow for a gradual decrease in the existing caseload through a combination of case closing and prioritization. Together, the local supervisor and the assigned attorney can work with benefit specialists to develop an approach that includes both local organizational adjustments and close monitoring of client services.

2. Limit Scope of Services

Benefit specialists help customers with a wide variety of public and private benefits issues. At times of high demand, it may be helpful to examine the types of issues your benefit specialist assists with in order to ensure the focus remains on core program services. Core services for the DBS program are outlined in the DBS Scope of Services document. The priorities of the EBS program are defined in Chapter 9 of the Manual of Policies, Procedures and Technical Assistance for The Wisconsin Aging Network. Services that fall outside of the programs' scope or are

identified as lower priority or "discretionary," such as assistance in filling out low-income tax credit forms, should be eliminated first. None of the core benefit specialist program services, such as Medicare Part D counseling and help with Social Security overpayments, may be eliminated without prior approval from state program staff at the Bureau of Aging and Disability Resources.

3. Limit Level of Involvement.

If caseload becomes unmanageable, a benefit specialist may need to exercise greater discretion in their level of involvement with client issues. If a client is capable, he/she should retain the primary responsibility for completing paperwork, gathering documentation, and meeting deadlines. The decision to act as the client's appointed representative for the purposes of a public benefits application must not be taken lightly, as this responsibility may increase the time it takes for a benefit specialist to develop and resolve a case.

4. Develop a Call Triage System for Handling Referrals

If a benefit specialist is struggling with an unmanageable caseload, it is important to examine the current referral system. Your agency should have a system for filtering calls before they are referred to a benefit specialist. Generally, a caller should not be directly transferred to the benefit specialist prior to a conversation with the receptionist or the information and assistance (I&A) specialist unless s/he is a current client of the benefit specialist or asks specifically for the benefit specialist. The benefit specialist's direct phone number should not be provided to the general public.

A call triage system may be an effective way to help the benefit specialist handle a high volume of requests for service. In a call triage system, the receptionist or I&A specialist attempts to determine the urgency of a particular caller's need for benefit specialist services. After gathering information from the caller about his/her immediate needs, the receptionist or I&A specialist rates the urgency of the caller's needs as **Level 1, 2 or 3**, according to the criteria outlined in *Exhibit A* (p. 6-7). This rating system is used by the benefit specialist in prioritizing return calls to the individuals who are referred to him/her.

The estimated call-back time for each level of urgency should be periodically reviewed and adjusted to accurately reflect the amount of time it will take for a benefit specialist to contact callers.

5. Consider Implementing a Wait List

When the demand for benefit specialist services has become unmanageable, a wait list may be an effective strategy to ensure that a benefit specialist can continue to provide high quality services. However, the decision to implement a wait list must be carefully considered. This strategy should not be implemented until other caseload management strategies have been explored. If possible, a wait list should be maintained on a temporary or seasonal basis only. Prior to implementing a wait list, local agency staff are encouraged to review their wait list plan with the benefit specialist's assigned attorneys, as well as state program staff at the Bureau of Aging and Disability Resources.

Some instances when a wait list may be appropriate include:

- The Medicare Part D annual election period
- Following introduction of a new benefit program such as the Badger Care Plus Core plan
- When a benefit specialist is on vacation or medical leave for an extended period of time
- During hiring and training of a new benefit specialist
- For temporary relief while other solutions are being explored

The basic guidelines and principles for a benefit specialist services wait list are:

1. A call triaging system must be in place to ensure that callers with urgent needs are served within one business day. Only clients whose needs are not identified as urgent should be placed on a waiting list.
2. Agency staff should record the date of the initial contact and any subsequent contacts.
3. Callers placed on a wait list should be notified that they are being placed on a waiting list and offered other appropriate agency services.
4. The benefit specialist will respond to callers on the wait list on a "first come, first served" basis, contacting those with Level 2 concerns prior to those with Level 3 concerns.
5. For cases involving public benefits denials, agency staff should err on the side of giving the caller a high priority.

6. Train Volunteers and Other Staff to Assist with Benefits-Related Issues

Other agency staff and trained volunteers may assist with some benefits-related inquiries and tasks, such as:

- Sending information to consumers who request basic materials (e.g., starter packet for the disability benefit application)
- Assistance in filling out the online initial disability application through Social Security
- Assistance in filing an initial application for FoodShare, Medicaid, or BadgerCare Plus through the online ACCESS tool (<https://access.wisconsin.gov/accessQ>).
- Completion of prescription medicines list and dosages to be entered in the online Medicare Part D Plan Finder tool
- Entering State Health Insurance Assistance data into the SHIPTalk.org database system, after confidentiality requirements have been explained

Given the variety and complexity of benefits, it is recommended that every consumer meet with a benefit specialist to obtain a thorough benefits check-up prior to filling out an initial application for benefits. Consumers should always be referred to a benefit specialist if their initial application for benefits is denied. Consumer situations that requires support from the benefit specialist's assigned attorney must be handled directly by a benefit specialist.

7. Identify and Address Commonly Asked Questions through Public Outreach

When it is clear there is a widespread need for basic information about a particular benefit program or issue, the benefit specialist may save time by disseminating information through public workshops, newsletters, written publications or an agency website. Reviewing the number and nature of information-only contacts may help you to identify the target audience and topics for outreach.

Public outreach to consumers and community partners on topics such as the online disability application process or use of the Medicare Part D plan finder tool can reduce the need for individualized counseling from a benefit specialist. A presentation to community partners that clarifies the scope of your services may help reduce the number of inappropriate referrals. Benefit specialists are encouraged to consult with their assigned attorneys in the development of presentation materials, since the attorneys are often able to assist in locating existing resources or developing something new to meet an identified need.

Summary

Any caseload management strategy to address the demand for benefit specialist services must take into consideration the workload of all staff at the agency. The local agency supervisor must take the lead role in developing and implementing strategies for managing a benefit specialist's caseload. Benefit specialists' assigned attorneys can provide valuable input during the assessment of the benefit specialist caseload and the development of strategies that will best serve customers. Decisions to restrict or eliminate services that fall within the traditional scope of benefit specialist services must be reviewed with state program staff at the Bureau of Aging and Disability Resources prior to implementation.

Questions about the Elder Benefit Specialist program should be directed to:

Rita Cairns, Legal Services Developer
Rita.Cairns@wisconsin.gov
(608) 267-3201

Questions about the Disability Benefit Specialist program should be directed to:

Phoebe Hefko, DBS Program Manager
Phoebe.Hefko@wisconsin.gov
(608) 266-8905

Source Documents

DBS Scope of Services, March 2010. Available on the Wisconsin Department of Health Services website at <http://www.dhs.wisconsin.gov/publications/p0/P00416.pdf>

A Manual of Policies, Procedures, and Technical Assistance for the Wisconsin Aging Network-Chapter 9: Elder Benefit Specialist Program. This publication is available on the Wisconsin Department of Health Services website at <http://www.dhs.wisconsin.gov/publications/P2/p23203.pdf>.

EXHIBIT A

Call Triage System Model

As noted in the Caseload Management Guidelines for Benefit Specialists, a call triage system may be effective ways to help benefit specialists handle a high volume of requests for service. As follows are some suggested criteria for prioritizing requests for benefit specialist services within your agency. The criteria set forth in this document may be adjusted as necessary to meet your agency's needs.

In the following call triage system model, a receptionist or I&A specialist attempts to determine the urgency of each caller's need for benefit specialist services. After gathering information from the caller to confirm he/she meets the criteria for benefit specialist services, the receptionist or I&A specialist rates the urgency of the call as **Level 1, 2 or 3**, according to the criteria outlined below. This rating system is subsequently used by the benefit specialist in prioritizing return calls to the individuals who are referred to him/her.

Level 1: Urgent

Estimated Wait Time: Same day or one business day

I&A/Receptionist action: Notify the benefit specialist that there is a caller with a Level 1 need. They may choose to speak with the caller immediately, or call the client back in one business day or less (unless the benefit specialist is on vacation or otherwise out of the office). If the benefit specialist is out of the office, refer the call to the benefit specialist's local agency supervisor. If in doubt as to whether a caller's need is urgent, it is best to err on the side of caution and identify the call as Level 1.

Level 1:

Description:

- Individuals who are not able to access their Medicare Part D and/or Medicaid to obtain needed prescription medications.
- Individuals who are in the process of appealing a Social Security Disability claim or a Medicaid claim, if the deadline for filing an appeal is less than two weeks away.
- Individuals who may be difficult to contact, including those who are homeless or in danger of becoming homeless, those who are living in unsafe/unstable home environments and those who seem to have a severe mental illness.
- Individuals who are terminally ill or who have catastrophic new conditions (e.g., lung cancer, severe brain damage). (It is not necessary to ask the person if they have a terminal illness or what their prognosis is; however, if they volunteer such information this information should be included in the referral.)
- Individuals who have SSI or SSDI as their only source of income and whose benefits are reduced or terminated due to an overpayment or loss of disability status.
- Individuals facing eviction. Staff should make an immediate referral to a legal services agency that provides representation in eviction hearings.
- Individuals with income less than 75% of the Federal Poverty Level who might qualify for SSI.

Level 2: Current Need and/or Brief Concern

Estimated Wait Time: One to three business days

I&A/Receptionist action: Inform caller that the benefit specialist will return their call in one to three business days. If an appointment is necessary, explain to the caller that they may be seen within one to two weeks, depending on the schedule of the benefit specialist.

Level 2 Description:

- Individuals who have general questions about Medicare Part D, or want to switch to a different Medicare Part D plan.
- Individuals who are appealing an eligibility or coverage determination and have an appeal deadline that is more than two weeks away.
- Individuals who have general questions about the disability process or about any other resources available to people with disabilities. Included in this category may be callers who state they have previously received services from the benefit specialist. These calls are more in-depth than benefits questions (e.g., How do I apply for disability?) fielded by I&A specialists.
- Individuals who have problems with reduced or incorrect benefit payments, as long as these problems are not causing extreme financial hardship, and as long as the appeal deadline is more than two weeks away.

Level 3: Non-urgent

Estimated Wait Time: Up to five business days

I&A/Receptionist action: Make a referral to the benefit specialist and inform caller that the benefit specialist will return their call in one to five business days. If an appointment is necessary, explain to the client that they may be seen within one month, depending on the schedule of the benefit specialist.

Level 3 Description:

- Individuals who want assistance with an initial application for Social Security Disability or the appeal of a Social Security Disability denial, as long as the appeal deadline is more than two weeks away. These comprise the majority of referrals to the disability benefit specialist and are the most time-consuming, often requiring 20 or more hours per client.
- Individuals who require assistance with applications for charitable funding for equipment or services not covered by public disability funds, unless there is an urgent need for the equipment or services.
- Individuals who are requesting help with issues identified as discretionary rather than core services for the benefit specialist programs, including Homestead Tax Credit forms, landlord-tenant issues, problems with creditors, and others.